Government Affairs Dept.
Mental Health Association in New Jersey

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PUBLIC POLICY STATEMENT

POSITION ON INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH CARE

STATEMENT OF THE PROBLEM

More than half of the individuals in New Jersey with behavioral health needs do not receive treatment[i]. In New Jersey 25 percent of individuals experience a mental illness and more than 178,000 have a substance use disorder. For those who do receive treatment, services are often fragmented and uncoordinated. Individuals with serious mental illness (SMI), in particular, die an average of 25 years earlier than the general population due to untreated, or inadequately treated physical health conditions, such as heart disease and diabetes[ii]. The opiate epidemic is reaching all-time highs and is a growing crisis among those affected, and their families. Those caught in the throes of opiate addiction are at very high risk for serious physical health conditions, including Hepatitis C, HIV, overdose and death.

Mental illness and substance use disorders frequently co-occur; however, recognition, diagnosis and treatment are often lacking or disjointed. In New Jersey, one third of individuals living with mental illness also abuse drugs and alcohol[iii]. For many, treatment remains inadequate and unavailable. The lack of coordination and integration of physical and behavioral health services in New Jersey leaves many at increased risk of serious health conditions and/or falling through the cracks.

In addition, those seeking primary health care services, who have a mild to moderate behavioral health condition, are often overlooked or misdiagnosed, leaving them without adequate behavioral health treatment. There is a strong need to address all levels of healthcare and treat the whole person.

A recent study found that a significant number of NJ Medicaid beneficiaries persistently fell within the “high utilizer” category. Medicaid is the primary funder of services for this population. High utilizers are those with persistently high spending costs due to repeated emergency room visits, inpatient hospital stays and complex behavioral and physical health conditions. Of them, more than 96% of the top 1% of Medicaid high utilizers had either a mental illness, substance use disorder or a co-occurring condition[iv].

New Jersey has benefited from Federal grants to fund and support the inception of an integrated physical and behavioral healthcare system from the Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA) and local grants. However, a significant barrier to the continuation of these valuable

programs, often occurs as the grants expire; New Jersey's funding mechanisms are unable to sustain the continuation of the programs.

Another systemic barrier to integrating behavioral and physical health in New Jersey includes the outdated and stigmatizing licensing regulations that make it difficult to offer the two services in the same location. The expensive and time-consuming alterations that are needed to make the physical space of integrated locations functional, along with licensure and regulatory obstacles, make true integration difficult.

Additionally, in September 2017, the State transferred DMHAS out of the Department of Human Services (DHS) – where Medicaid is housed – and into the Department of Health (DOH). Separating the funding source (Medicaid) from the service providers and consumers can create additional barriers to treatment.

HISTORY AND BACKGROUND

Mental illness, addiction and co-occurring disorders affect individuals of all demographic, regional and socioeconomic backgrounds, and impacts approximately one in four of New Jersey's nearly 9 million residents. According to MHANJ's NJ Connect for Recovery call line, greater than 50 percent of callers have a co-occurring substance use and mental health condition[v]. According to the FY2016-2017 Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant Application, in 2014 there were 46,441 unduplicated public substance abuse treatment admissions and 323,501 unduplicated individuals who received public mental health services[vi].

In recognition of the prevalence of mental health and substance use disorders, and in an effort to integrate care, the state merged the Division of Mental Health with the Division of Addiction Services in 2011, to create the Division of Mental Health and Addiction Services. Although these two divisions have merged into one, their integration at the community level is problematic and limited, in part because they continue to receive separate funding streams, which keeps their services siloed.

Federally Qualified Health Centers (FQHCs) are the main source for primary health care services for individuals with Medicaid in NJ. There are 23 FQHCs in NJ, with 129 locations throughout all 21 counties. Some FQHCs offer behavioral health services in the form of a Brief Screening, Intervention, Referral to Treatment (SBIRT). In addition to SBIRT, some FQHCs offer behavioral health treatment for mild to moderate mental illness.

National trends are shifting to integrate behavioral health and physical healthcare services. Over the last decade, the safety net system of health care has approached a tipping point, such that many states can no longer afford to keep behavioral health services under a fee-for-service (FFS) system and/or separated from physical health benefits[vii]. Many states are currently exploring ways in which to manage behavioral health services, which include: value-based reimbursement based on quality and utilization; integrating primary care and behavioral health services through financing and programmatic strategies; integration of physical and behavioral health care with housing, employment, and other vital support systems; and paying attention to funding the services that affect social determinants of health.

MHANJ Position

Research shows that individuals living with behavioral health conditions, especially those with severe mental illness, are at the greatest risk of early death, often due to uncoordinated and poorly managed physical health care. Our most vulnerable citizens deserve integrated care that offers appropriate services to improve overall health outcomes and the opportunity for achieving wellness and recovery.

There is a great need for a dedicated behavioral health integration initiative in New Jersey, now more than ever, with the growing opiate epidemic. MHANJ Believes:

- Systemic changes are needed to allow for the integration between mental health and addiction treatment along with physical health care in behavioral health care settings
- Behavioral health needs to be available to persons in primary health care settings where early identification, assessment, treatment and referral (SBIRT) can occur for persons at rise
- Advocacy must focus on reducing barriers and providing incentives to have these sustainable services available in the community

MHANJ Recommendations

The primary focus of our recommendations is to increase access to care and enhance integration of behavioral and physical healthcare services in New Jersey.

A. Managed System Recommendations:
    - Appoint a policy leader within the Governor's office to require planning and accountability among divisions and departments to sustain progress, including funding, and develop outcome measures and sustainability.
    - Develop a management system that will blend the public systems treatment modalities of physical and behavioral health care based on New York's HARP Model (Health and Recovery Plans).
    - A HARP is a managed care product that manages physical health, mental health, and substance use services in an integrated way for adults with significant behavioral health needs as well as high utilizers.
    - HARPs manage the Medicaid services for people who need them, manage an enhanced benefit package of Home and Community-Based Services (HCBS) and provide enhanced care management for members to help them coordinate all their physical health, behavioral health as well as social determinants that are currently non-Medicaid reimbursable (i.e. transportation, housing, legal, etc.).
    - Identify the pitfalls of NY's HARP model, as applied to New Jersey, for example, choosing financing and oversight systems that work for NJ and dealing with the limitations inherent in MCO systems.

B. Medicaid Recommendations:
    - Since Medicaid is the largest payer of services for New Jersey's most vulnerable citizens, we recommend moving DMHAS to the Department of Human Services where Medicaid is housed as well as the social determinants programs utilized by vulnerable populations residing in the community.
    - Assure that Medicaid Waiver includes coverage for social determinants (e.g. housing, transportation, employment) in order to provide a full continuum of recovery services[viii].

- Re-visit Medicaid payment rates to incentivize integration and assure the needs of consumers are effectively met
- Develop a management payment system that will ensure sustainability

C. Service Delivery Recommendations:
   - Require meaningful stakeholder and consumer comment and involvement through every level of planning and implementation.
   - Increase inadequate fee-for-service (FFS) rates that exist for the SMI population in order to sustain and improve access to integrated care.
   - Redefine realistic regulatory requirements for integrating care[ix]
   - Address FQHC disincentives to partnering with behavioral health and remove barriers that keep FQHC's from being able to offer behavioral health services[ix]
   - Pursue a single licensure goal to integrate care; eliminate dated and stigmatic requirements for separation of PH and BH patients[ix]
   - Increase the use of quality telemedicine when needed/appropriate and educate providers, the public and consumers about benefits of this service to complement (but not to replace) in person appointments and increased access to care.

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[i] SAMHSA Behavioral Health Barometer, New Jersey, Volume 4
[ii] National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council Morbidity and Mortality in People with Serious Mental Illness
[iii] National Alliance on Mental Illness (NAMI) Information on Dual Diagnosis
[iv] Rutgers Biomedical and Health Sciences, Analysis and Recommendations for Medicaid High Utilizers in New Jersey
[v] MHANJ NJ Connect for Recovery Opiate Support Call Line
[vi] New Jersey Uniform Application FY 2016/2017 - State Behavioral Health Assessment and Plan, Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant
[vii] Health Management Associates, National Trends in Behavioral Health Management
[viii] US Department of Health and Human Services Announces First-ever CMS Innovation Center pilot project to test improving patients' health by addressing their social needs
[ix] Seton Hall Law, Center for Health & Pharmaceutical Law & Policy: Integration of Behavioral and Physical Health Care: Licensing and Reimbursement Barriers and Opportunities in New Jersey

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